Chart No._____

LUXE
AESTHETICS

Patient Information

Patient Name: _____

Date of Birth: _____ ☐ Female ☐ Male

Address: _____

Phone (Home): _____
Contact Preference: Home ☐ Cell ☐

Phone (Cell):_____
Permission to call: Yes ☐ No ☐

Permission to text: Yes ☐ No ☐

Email Address:_____ **Marital Status:**_____

I would like to receive emails about special offers: Yes ☐ No ☐

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Language: ☐ English ☐ Spanish ☐ Other

Emergency Contact: _____

Phone: _____ **Relation to Patient:** _____

We may contact your Emergency Contact listed above regarding (**choose one** of the following boxes):

- ☐ All Healthcare, Scheduling, and Payment Information
- ☐ Only Scheduling and Payment Information
- ☐ Only for purposes of contacting me, once all direct patient contact avenues have been exhausted

Primary Insurance:_____ **Policy Number:** _____

Secondary Insurance: _____ **Policy Number:** _____

How did you hear about Luxe Aesthetics?

- ❏ Doctor Referral: _____
- ❏ Friend or Relative: _____
- ❏ Our Website
- ❏ Other: _____

By signing this authorization below I acknowledge the following:

- The information I have provided above is correct and most current to the best of my knowledge
- That failure to notify Luxe Aesthetics of any changes to my contact information and insurance(s) in a timely-manner may delay treatment and/or result in additional out-of-pocket costs due to the time-sensitive manner of insurance authorizations for treatments and procedures.

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LUXE AESTHETICS

What are your concerns? Check all that apply:

- ☐ Forehead
- ☐ Eyebrows
- ☐ Upper eyelids
- ☐ Lower eyelids
- ☐ Eyelashes
- ☐ Tearing
- ☐ Frown lines
- ☐ Crows feet or smile lines
- ☐ Lines around the nose / mouth
- ☐ Corners of the mouth
- ☐ Lips
- ☐ Other: _____
- ☐ Pigmented Lesions
- ☐ Unwanted facial hair
- ☐ Facial veins
- ☐ Rosacea
- ☐ Scar revision
- ☐ Skin rejuvenation
- ☐ Skin Care recommendation
- ☐ Botox
- ☐ Filler
- ☐ Microneedling / Microneedling with PRP (Platelet Rich Plasma)
- ☐ Chemical peel

What bothers you the most? _____

Does it interfere with:

- ☐ Driving
- ☐ Computer work
- ☐ Other:_____
- ☐ Reading
- ☐ Social activities

Have you had any surgery or injury to the face?

_____

Do you have any history of skin cancer? If yes, what type and where?

_____

What is your biggest concern regarding oculofacial plastic and reconstructive surgery?

_____

Please check **one** of the below statements:

- ☐ I understand that my visit today is insurance based and will be billed to my insurance and I am responsible for my out-of-pocket portion.
- ☐ I understand that my visit today is considered self-pay and will NOT be billed to my insurance. The cost of my visit is $200.
- ☐ I understand that my visit is considered a cosmetic consultation and will NOT be billed to my insurance. The cost of my visit is $200 and can be put towards any future cosmetic surgeries and **same day** aesthetic injectable services such as fillers, Botox, and Xeomin injections.

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LUXE AESTHETICS

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Luxe Aesthetics's Notice of Privacy Practices effective immediately.

* _____

Patient Name

* _____ _____

Patient Signature Date

For the legal guardians of patients under the age of 18 years:

I am a parent or legal guardian of _____ (patient name). I have received a copy of Luxe Aesthetics's Notice of Privacy Practices effective immediately.

Name of guardian (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

_____ _____

Signature Date

FOR CLINIC USE ONLY:

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it. Notice of Privacy Practices effective immediately, given to individual on _____ (date) _____

☐In Person ☐Mailing ☐Email ☐Other

Reason individual or parent/legal guardian did not sign this form:

☐Did not want to ☐Did not respond after more than one attempt ☐Other

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐In person conversation ☐Telephone contact ☐Mailing ☐Email ☐Other

Staff Name (please print):_____ Title:_____

Staff Signature: _____ Date: _____

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LUXE
AESTHETICS

Photo/Video Release Form

Insurance companies require that Luxe Aesthetics take photos, and in some cases videos, in order to document the current status of the patient's physical conditions and wellbeing. These photos will be recorded only in the patient chart and sent to the insurance companies when necessary.

By signing below you consent to have Luxe Aesthetics to take and use my photos for insurance purposes. I have read and fully understand this release before signing below and I fully understand the contents, meaning, and impact of this release.

* _____ _____

Signature of Patient Date

_____

Printed Name of Patient

If the person signing is under age 18, there must be consent by a parent or guardian, as follows: I hereby certify that I am the parent/guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

Luxe Aesthetics would also like to use your photos, and in some cases videos, for employee training purposes as well as to represent and publicize our quality of services in our publications, website, and other media outlets.

By signing below, I authorize Luxe Aesthetics to use my physical likeness in any format without payment or any other consideration and waive any right to royalties or other compensation related to the use of the photo or video likeness. I understand and agree that these materials will become the property of Luxe Aesthetics and will not be returned. I authorize Luxe Aesthetics to edit, alter, copy, exhibit, publish or distribute this photo or video likeness for purposes of publicizing Luxe Aesthetics's programs or for any other lawful purpose, including joint advertising. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears.

_____ _____

* Signature of Patient (Must be over 18 years of age) Date

_____

Printed Name

If the person signing is under age 18, there must be consent by a parent or guardian, as follows: I hereby certify that I am the parent/guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

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LUXE AESTHETICS

Patient Financial Policy

Luxe Aesthetics considers it a privilege that you have chosen us for oculofacial plastic surgery care. Luxe Aesthetics provides both reconstructive and cosmetic/aesthetic plastic surgery treatments for the eyes. Our providers implement reconstructive plastic surgery approaches to improve body function due to birth defects, injury, disease, or aging. Our providers also provide cosmetic and aesthetic services to partner with our patients to help them reach their aesthetic goals. In order to provide you with the best treatment plan recommendation, our providers may refer you for further consultation and/or treatment. We strive to inform you of all the medical aspects involved as well as our financial policy. Please read the following and sign prior to your procedure. We are happy to answer any questions that you may have.

Insurance Related Consultations and Services:

- Your insurance card is required at the time of check-in.
- If we participate with your insurance, applicable consultation fees will be billed to your insurance and you will only be expected to pay deductibles, co-insurances, copays and any non-covered services.
- You will be expected to pay any copays or estimated out-of-pocket amounts at the time of service
- Your insurance may have separate copays for the consult visit itself and any other additional services that are provided at your consult visit, i.e. photos & photo interpretation, nasal endoscopy, probe and irrigation of the tear ducts. Luxe Aesthetics will always bill your insurance and will notify you of any costs they deem is your responsibility.
- As a courtesy, we will file your claims for you with your primary and secondary insurance carriers. Ultimately, you accept responsibility for payment in full to Luxe Aesthetics, not your insurance.
- You will be quoted and expected to pay any amounts your insurance will not pay one week prior to your procedure. This will include our best **estimate** of only the surgeon's fee. The facility and anesthesia fees will be billed to you separately. Please contact those providers directly with any questions about their fees.
- If your insurance requires a referral, please have your primary care physician fax it to our office prior to your appointment or you may be rescheduled.
- We gladly accept cash, check, Mastercard, Visa, American Express, Discover and Carecredit. All checks should be made out to Luxe Aesthetics.If your check is returned, you will be charged a return check fee and your checks will no longer be accepted for future payments.
- **The patient has the responsibility to immediately notify Luxe Aesthetics of any insurance policy changes and failure to do so may result in the accruement of additional out-of-pocket costs.**
    - Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment.
- **It is the patient's responsibility to understand their benefit plan. It is their responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.**
- For reconstructive procedures: All surgeon fees provided by Luxe Aesthetics are our best **estimates** dependent upon the patient's insurance policy.
    - All out-of-pocket portions of surgeon fees will be adjusted after the insurance payment received post-surgery.
        - In the case that the out-of-pocket cost is lower than expected, the patient may choose to receive a refund payment or elect to use the balance as a credit
        - towards future appointments/treatments.
        - In the case that the out-of-pocket cost is higher than expected, the patient will be held responsible for the remaining balance.

- In the case that any additional procedures are performed, you will be notified of the out-of-pocket cost as delineated above.

Cosmetic/Aesthetic Consultations and Services:

- All Cosmetic Consultation fees are $200. This fee will be credited towards your cosmetic surgical procedure.
    - This fee may be put towards **same day** Botox, Xeomin, and filler services**,** but not for later-date services.
    - This does not apply to any laser or chemical peels, but please speak with our aesthetician about ongoing specials.
- All subsequent office visits with our providers, including pre-op appointments, are $175 unless covered within your post-operative period of 90 days following surgery or unless other aesthetic services are rendered that day.
- A $300.00 deposit is required in order to secure a date for your surgery. This fee is non-refundable and will be credited towards your cosmetic surgical procedure.
- We understand that unforeseen events happen. Upon proper notice you may reschedule your surgery one time.
- Payment for the balance of your surgery is due one week prior to your surgery date. If payment is not received the surgery will be canceled. We accept cash, check, Master Card, Visa, American Express, Discover, and Care Credit.
- If you pay by check you will be required to pay two weeks in advance. If the check is returned, you will be charged a return check fee and your checks will no longer be accepted for future payments.
- You may ask our office staff or visit our website to apply for Care Credit and Alphaeon Credit. Please ask us what Care Credit and Aphaeon Credit terms we offer.

Self-Pay Consultations and Services:

- For self-pay patients, payment in full is expected at the time of the office visit and prior balances must be paid prior to the following visit with the exception of emergency visits.
    - All initial consultation visits are $200 and any other procedures or services are at additional costs which will be discussed with you. Any subsequent office visits are $175.
    - All initial post-op visits for self-pay surgeries are covered at no-cost to patients.

Payment Plans

- It is the patient's responsibility to make payment arrangements with the practice to ensure that the practice has the correct contact information including phone numbers, mailing addresses, and email addresses.
- If there is an outstanding patient balance, the practice will mail all statements and make attempts to contact the patient via phone and email.
- Bills unpaid after three statements have been sent to the patient may be turned over to a collection agency after 90 days unless other arrangements have been made.
- Patients with outstanding balances and no payment arrangements will not be seen by the practice until payment arrangements are made with a down payment, unless the patient is experiencing an emergency that requires immediate attention.
- Our practice is glad to work with our patients to find a reasonable and appropriate payment plan.

Forms, Medical Records and Fees

- There may be a fee associated with the completion of documents including forms. All documents will be

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completed within 7 business days and sent out upon receipt of payment. ○ Family and Medical Leave Act (FMLA) forms and other medical forms have an associated fee of $25.00 to cover health professional time for completion of the form.

- ○ Work and School release letters will be provided at no cost to the patient.
- ○ Patients with multiple medical forms/documents will be charged a discounted rate for the additional forms.

- Hard copies of patient requested medical records have an associated fee of $15.00 to cover printing costs. This is applicable only to hard copies and digital copies will be shared to patients at no cost via e-mail or fax.
  - ○ Patients should be aware that these records may be found in their Athena Patient Portal.

Authorization: I have read and fully understand the financial policy set forth by Luxe Aesthetics. I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company and any other party to make payments directly to Luxe Aesthetics. I agree to pay any cost incurred if my account should become delinquent. I have read, understand and agree to this financial policy and I accept full responsibility for any balance due. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient.

*

_____ _____

Patient Signature Date

Chart No._____

LUXE
AESTHETICS

Patient Insurance Policies

Luxe Aesthetics does their best to ensure that all patients' insurances are verified for eligibility, i.e. to know whether our providers are in-network with the patient's policy. Due to the high number of policy plans and specifications, it is not possible for Luxe Aesthetics to know the intimate details of each patient's personal insurance policy.

By signing below I acknowledge that I understand the following:

- That the primary relationship for insurance coverage is between myself and my insurance provider. I have the ultimate responsibility to know which practices and providers are in-network with my specific insurance plan.
- Luxe Aesthetics cannot be held responsible for any policy restrictions or coverage that the insurance company determines.
- Luxe Aesthetics is unable to provide me with out-of-pocket costs outside of the estimates provided by my insurance company to Luxe Aesthetics and that the exact cost will only be made known to Luxe Aesthetics and therefore to the patient after the services are completed.
- That I must notify Luxe Aesthetics if my insurance policy or providers have changed and that any delay in doing so will result in delay of services and cancellation of appointments or procedures among other potential consequences.
- That whatever my insurance company does not cover is my responsibility to pay in full. I understand that I have the right to arrange a prepayment plan with Luxe Aesthetics based on the estimate provided by Luxe Aesthetics.

By signing below, I acknowledge that I have read and understand the above relationship between Luxe Aesthetics, my insurance provider, and myself.

* _____ _____

Patient Signature Date